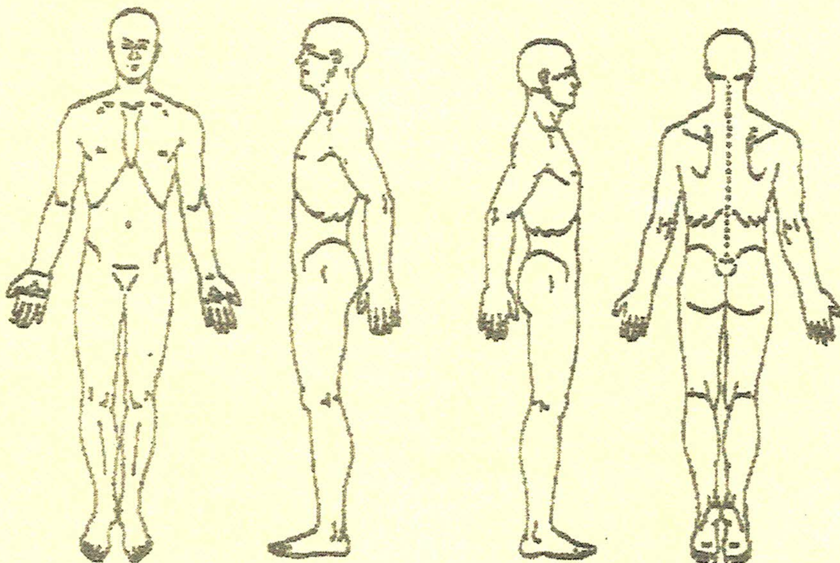
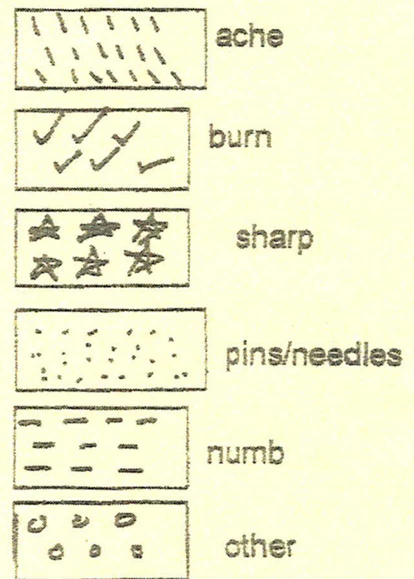
COMSTOCK PHYSICAL THERAPY PATIENT HISTORY FORM

Patient Name: ______________________________ Date of Birth: __________
Date: __________ Occupation: ______________ Diagnosis: __________
Last Physician Visit: __________ Next Physician Visit: __________

Do you have or have you had any of the following conditions:

Allergies	Yes ○ No ○	Dizzy Spells	Yes ○ No ○	MRSA	Yes ○ No ○
Anemia	Yes ○ No ○	Emphysema Bronchitis	Yes ○ No ○ Yes ○ No ○	Multiple Sclerosis	Yes ○ No ○
Anxiety	Yes ○ No ○	Fibromyalgia	Yes ○ No ○	Muscular Disease	Yes ○ No ○
Arthritis	Yes ○ No ○	Fractures	Yes ○ No ○	Osteoporosis	Yes ○ No ○
Asthma	Yes ○ No ○	Gallbladder Problems	Yes ○ No ○	Parkinson's	Yes ○ No ○
Autoimmune Disorder	Yes ○ No ○	Headache	Yes ○ No ○	Rheumatoid Arthritis	Yes ○ No ○
Cancer	Yes ○ No ○	Hearing Impairment	Yes ○ No ○	Seizures	Yes ○ No ○
Cardiac Conditions	Yes ○ No ○	Hepatitis	Yes ○ No ○	Smoking	Yes ○ No ○
Cardiac Pacemaker	Yes ○ No ○	High Cholesterol	Yes ○ No ○	Speech Problems	Yes ○ No ○
Chemical Dependency	Yes ○ No ○	High/Low Blood Pressure	Yes ○ No ○	Stroke	Yes ○ No ○
Circulation Problems	Yes ○ No ○	HIV/AIDS	Yes ○ No ○	Thyroid Disease	Yes ○ No ○
Currently Pregnant	Yes ○ No ○	Incontinence	Yes ○ No ○	Tuberculosis	Yes ○ No ○
Depression	Yes ○ No ○	Kidney Problems	Yes ○ No ○	Vision Problems	Yes ○ No ○
Diabetes	Yes ○ No ○	Metal Implants	Yes ○ No ○		





Describe any other conditions:

Fall History:

Injury as a result of a fall in the past year? Yes ○ No ○
Two or more falls in the last year? Yes ○ No ○
Patient is at risk for falls? Yes ○ No ○

Surgical History:

Body Region: ____________________ Surgery Type: __________________ Date: ____________

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Current Medications:

Drug:__________________ Dosage: _____ Frequency: ______ Route: ______ Reason____________

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